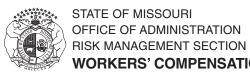


CENTRAL ACCIDENT REPORTING OFFICE (CARO) P.O. BOX 809 **JEFFERSON CITY, MO 65102** 573-751-2837 TOLL FREE 1-888-622-7694

AUTHORIZATION TO RELEASE MEDICAL RECORDS -WORKERS' COMPENSATION

T	o Whom It May Concern:							
I,	the undersigned,	DE NAME		······ ,				
	, do hereby request and authorize any medical health care provider, upon presentation							
0	of this authorization, to disclose to the State of Missouri, Central Accident Reporting Office, or its							
representative, including the Attorney General of Missouri and his Assistants, any material or information								
C	oncerning		with respect to	illness or injury,				
m	nedical history, consultation, treatment including but not limited	to x-rays, m	edical histories	s, nurses' notes,				
р	rescriptions and copies of all hospital or medical records. A pho-	otostatic cop	y of this autho	rization shall be				
C								
Т	his is not a release of any claim I may have.							
			T					
D			DATE					
T AD	DRESS							
		STATE		ZIP CODE				



CENTRAL ACCIDENT REPORTING OFFICE (CARO) P.O. BOX 809 **JEFFERSON CITY, MO 65102** 573-751-2837

WORKERS' COMPENSATION DISABILITY LEAVE OPTIONS

EMPLOYEE'S NAME (LAST, FIRST, MI)			DATE OF INJURY	CARO NUMBER						
I understand that I have the following options available to me while I am unable to work due to a work-related injury covered										
by workers' compensation.										
CHECK ONE:										
I elect to receive workers' compensation temporary total disability benefits for my lost time calculated at sixty-six and two-										
thirds percent of my average weekly wage not to exceed the maximum set by law. I understand I may request to use my										
accumulated vacation and/or accumulated compensatory time which may be approved, and there will be no reduction in										
my workers' compensation temporary total disability benefits.										
	EFFECTIVE DATE									
☐ I elect to have my accumulated sick leave applied to my lost time in lieu of receiving workers' compensation temporary total disability benefits without affecting my right to medical and permanent disability benefits, if any. If the sick leave option										
is selected, workers' compensation temporary total disability benefits as provided by law may begin as soon as my sick										
leave balance is depleted or I change my option.										
isans salames is deploted on a sharinge my option.										
		EFFECTIVE DATE								
After choosi	ng one of the above described	options, I have	the right to file a revis	sion of this form changing my	option. The					
change will become effective on or after the date I sign the revised form.										
	EMPLOYEE'S SIGNATURE		DATE OF SIGNATUR							
	WITNESSES SIGNATURE		DATE OF SIGNATUR							